Missouri Department of Social Services
Division of Aging

ABUSE, NEGLECT AND EXPLOITATION OF SENIORS AND ADULTS WITH DISABILITIES

Annual Report
Fiscal Year 2000

Research and Evaluation
May 2001

Division of Aging

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Annual Report

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Department of Social Services
Mission Statement

To maintain or improve the quality of life for the people of the state of Missouri by providing the best possible services to the public, with respect, responsiveness and accountability, which will enable individuals and families to better fulfill their potential.

Division of Aging
Mission Statement

To promote, maintain, improve, and protect the quality of life and the quality of care for Missouri's older adults and persons with disabilities so they may live as independently as possible with dignity and respect.

BOB HOLDEN
GOVERNOR

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Dear Reader:

The Missouri Division of Aging is pleased to present the fourth edition of the *Elder Abuse, Neglect and Exploitation Annual Report.* Material in this report covers activities completed during Fiscal Year 2000 (July 1, 1999 through June 30, 2000).

The information provided in this report includes data for both Home and Community and Institutional Services programs. The Division of Aging provides services to seniors, persons with disabilities age 18 to 59, and residents of nursing facilities. We hope this report will be useful to anyone interested in the issue of abuse, neglect, and exploitation within these groups.

Elder abuse is a widespread problem affecting hundreds of thousands of elderly people across the country. However, it is believed to be largely under-reported because of shame and the shroud of family secrecy. Some experts estimate that as few as 1 out of 14 elder abuse incidents come to the attention of authorities, and reports received by the Aging Hotline represent only a small portion of the problem.

Questions about the report should be directed to the Department of Social Services Research and Evaluation Unit at (573) 751-3060 or the Division of Aging Home and Community Services Policy Unit at (573) 522-8689.

Sincerely,

Richard C. Dunn
Director

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Introduction

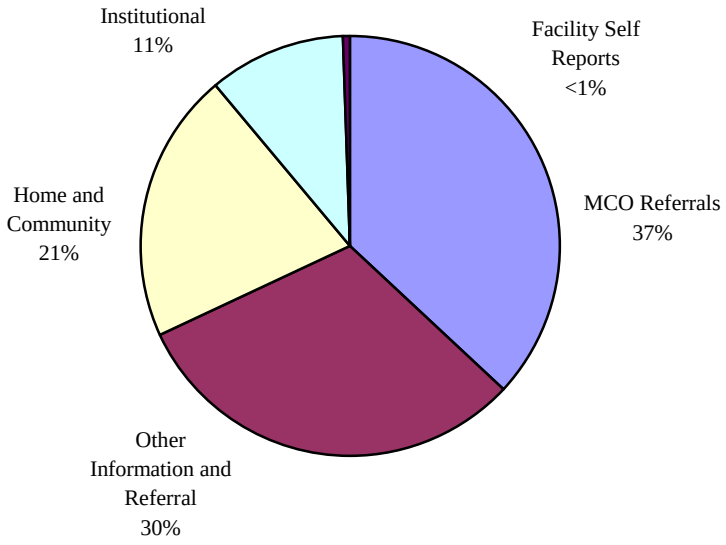
In October 1980, the Missouri Department of Social Services' Division of Aging (DA) established a central registry to accept and refer reports of abuse and neglect of elderly adults through a statewide hotline. In 1987, protective services were extended to disabled adults. The Central Registry Unit (CRU) currently handles calls regarding disabled and elder abuse, neglect and exploitation (A/N/E); regulation violations in institutional facilities licensed by DA; screening referrals for Missouri Care Options (MCO); referrals to other agencies; and, requests for information. The Division of Aging CRU abuse and neglect hotline operates year-round, 24 hours each day and may be reached at **1 (800) 392-0210**.

This report synthesizes data collected by the CRU on individual reports and completed investigations of A/N/E of elderly and disabled adults during fiscal year 2000.

Intake Activities

- During fiscal year 2000, DA received 67,063 calls, a decrease of one percent from fiscal year 1999.
- Over one-third of total intake activities were MCO referrals. The MCO program informs persons considering nursing facility care of available long-term care options. In fiscal year 2000, MCO referrals increased two percent to 24,775.

Central Registry Unit Intake Activities
FY 2000



- The second largest number of calls received by the CRU, 30 percent, were for information requests and referrals to other agencies (Other I&R). This included referrals to Area Agency on Aging (AAA) offices; Alzheimer's information and support group referrals; heat crisis and cooling center information; Governor's Silver Club applications and information; referrals to local DA Offices; and, referrals to other agencies. During fiscal year 2000, the CRU received 20,894 information requests and referrals to other agencies, a six percent decrease from the previous year.

- Over 20 percent of hotline calls were reports of A/N/E in a home or community setting. In fiscal year 2000, CRU registered 13,853 hotline reports, a decrease of nearly two percent from fiscal year 1999.

- Reports of abuse/neglect in long-term care facilities or regulation violations in DA licensed facilities comprised nearly 11 percent of the total number of calls to the CRU. These reports decreased three percent from fiscal year 1999.

- As of February 1998, policy revisions eliminated statements of concern incorporating these reports into other categories of reports. In fiscal year 2000, the CRU received 372 facility self-reports. Facility self-reporting is a process established to allow facility representatives to self-report incidents occurring in the facility to the division. A self-report is not considered to be a complaint report. However, based upon information collected by CRU and investigative staff, a determination by division staff may be made to investigate and convert the incident into a complaint report if violations are determined to exist.

Investigations

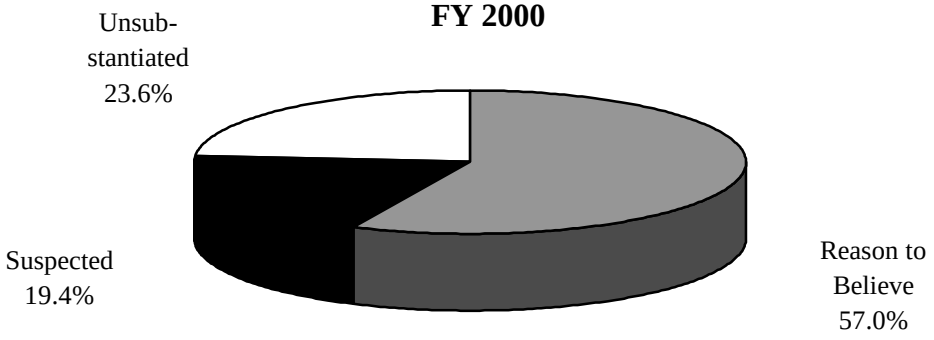
Upon report of an incident of A/N/E or a regulation violation, the CRU logs the information and forwards it to the DA field staff for investigation. After the investigation is complete, the investigator determines if A/N/E occurred or if the regulation violation was valid. The investigative findings are sent back to the CRU for entry into the Central Registry for Abuse, Neglect and Exploitation (CRANE) database. As applicable, results of investigations are referred to the appropriate law enforcement agencies and the Attorney General for their action. Local Home and Community Service (HCS) field staff also accept reports and forward them to the CRU to be registered.

It should be noted that the number of reports differ from the number of investigations in any given fiscal year. "Report" refers to an allegation of A/N/E or regulation violation during the fiscal year. "Investigation" refers to a completed review of the report for which the findings were entered into the CRANE database. For example, a report could have been made in June and also investigated in June, but findings may not have been entered into the database until July. Therefore, the report will be counted in one fiscal year and the investigation will be counted in the following fiscal year.

Introduction

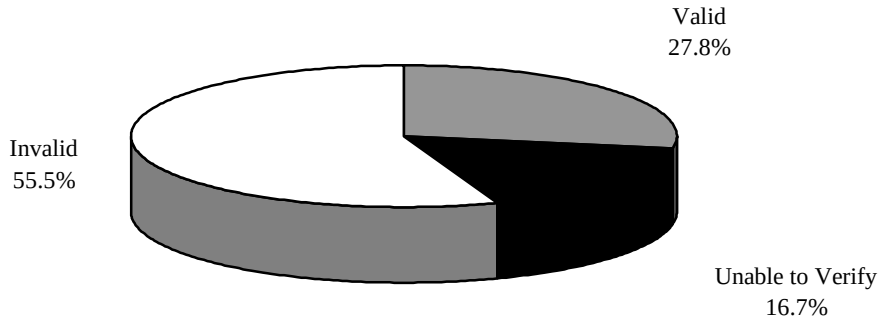
The CRU received 12,572 completed investigations of home and community A/N/E in fiscal year 2000. Consistent with previous years, investigators found reason to believe that A/N/E occurred in 57 percent of these investigations, and suspected and unsubstantiated findings accounted for 19 percent and 24 percent, respectively, of total investigations.

Home and Community Completed Investigations of Seniors and Adults with Disabilities Abuse, Neglect or Exploitation FY 2000



The CRU received findings from 8,704 investigations of abuse/neglect and regulation violations in institutional settings. The majority of reports were found to be invalid. Seventeen percent were not able to be verified (down from 21 percent in fiscal year 1999) while 28 percent were determined to be valid.

Institutional Completed Investigations of Seniors and Adults with Disabilities Abuse, Neglect or Exploitation FY 2000



Initial Reports

Intake social workers record the following information when a report is made to the CRU:

- the name, address and telephone number of the victim;
- the name, address and telephone number of other persons significant to the victim;
- the nature and extent of the victim's condition and the nature of A/N/E;
- the name of the reporter (which is held confidential); and,
- the identity of the perpetrator (if applicable).

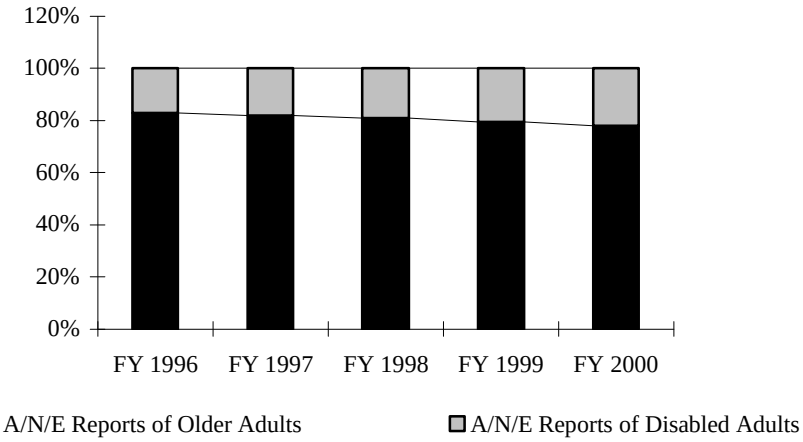
This information is forwarded to a county office for investigation. If the investigator discovers a crime occurred, the information may be referred to additional agencies for appropriate action.

Reports of Home and Community A/N/E of Seniors and Adults with Disabilities

	A/N/E of Seniors	Annual Change	A/N/E of Disabled Adults	Annual Change	Total Reports	Annual Change
FY 1996	9,916	-2.3%	2,060	5.3%	11,976	-1.1%
FY 1997	10,342	4.3%	2,281	10.7%	12,623	5.4%
FY 1998	10,833	4.7%	2,553	11.9%	13,386	6.0%
FY 1999	11,209	3.5%	2,890	13.2%	14,099	5.3%
FY 2000	11,477	2.4%	3,255	12.6%	14,732	4.5%

Home and community A/N/E reports increased for the fourth year after previous declines. The majority of reports involve older adults though the number of reports concerning disabled adults has grown 58 percent since fiscal year 1996. The proportion of disabled adult A/N/E reports of total reports increased nearly two percent in fiscal year 2000 continuing a six year trend.

Reports of Home and Community A/N/E of Seniors and Adults with Disabilities



Reporters

Missouri law mandates health care, social service, law enforcement, religious and other professionals who provide services to elderly and disabled adults to report suspected A/N/E to the Department of Social Services. (For a complete list of mandated reporters see Appendix J, page 38.)

In fiscal year 2000, over half of the home and community A/N/E reports were from mandated reporters. Health care professionals, such as doctors, nurses, and hospital social service employees provided 24 percent of reports. The victim reported A/N/E in six percent of reports while relatives of the victims were the reporters 16 percent of the time. The proportion of reporters in fiscal year 2000 is consistent with prior years.

Reporters of Home and Community A/N/E of Seniors and Adults with Disabilities FY 2000

Reporter	Number of Reports	Percent of Total
Health Care Professional	1,872	12.7%
Hospital Social Services Employee	1,696	11.5%
Child/Spouse/Grandchild	1,170	7.9%
Friend/Neighbor/Landlord	1,555	10.6%
Anonymous/Unknown	1,311	8.9%
Self	925	6.3%
Other Relative	1,242	8.4%
In-Home Services Provider	1,457	9.9%
DSS/Division of Aging Employee	671	4.6%
Long-term Care Employee	1,345	9.1%
Other	637	4.4%
Law Enforcement	632	4.3%
Area Agency on Aging	101	0.7%
Government Official	118	0.7%
Total	**14,732**	**100.0%**

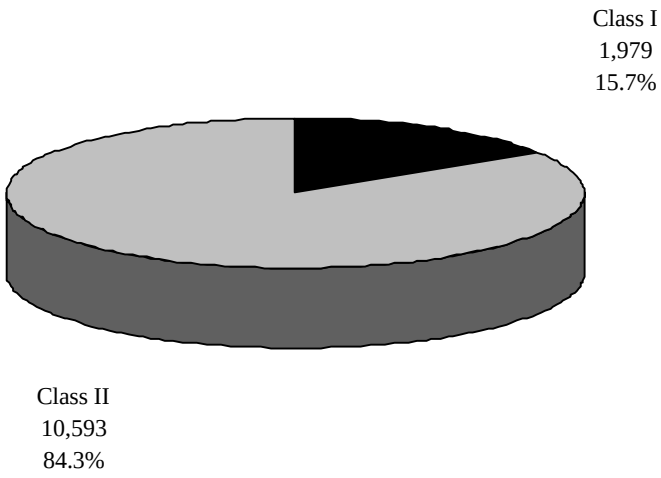
Note: Other includes Ombudsman, other residents, guardian, legal counsel and clergy.

Report Classification and Investigation Time Frames

In fiscal year 2000, the results of 12,572 completed investigations were entered into the CRANE database. The report classification describes the severity of A/N/E and determines the time frame in which the investigator must conduct a face-to-face investigation. Class I reports involve life-threatening, imminent danger situations which indicate a high risk of injury or harm to an eligible adult. An investigator attempts to meet face-to-face with the victim of a Class I report within 24 hours. Class II reports involve A/N/E which does not pose an immediate danger to the safety or well-being of an eligible adult. Completion of an investigation and face-to-face contact are attempted within seven days. Class III reports are non-protective services situations and do not always result in face-to-face contact.

Fiscal year 2000 Class I reports accounted for nearly 16 percent and Class II for 84 percent of the total home and community A/N/E investigations. Class III or non-protective service investigative findings are not registered at CRU. The investigator met with the victim within 24 hours in 91 percent of the Class I investigations. For Class II investigations, 87 percent of the time investigators met with the victim within seven days of the report. Some reports may not have been investigated within the specified time frame because of not being able to locate the victim, the victim was uncooperative or was moved to a protective environment.

Report Classification
of Completed A/N/E Investigations
of Seniors and Adults with Disabilities
FY 2000



Investigative Findings

The investigators determine the factuality of the reports and classify their findings into the following categories: reason to believe, suspected and unsubstantiated. A reason to believe finding is returned when a substantial amount of evidence is found supporting the allegations contained in the reports. A/N/E is suspected when the reported allegations are probable or likely. A report is unsubstantiated when the evidence does not support the allegations in the report.

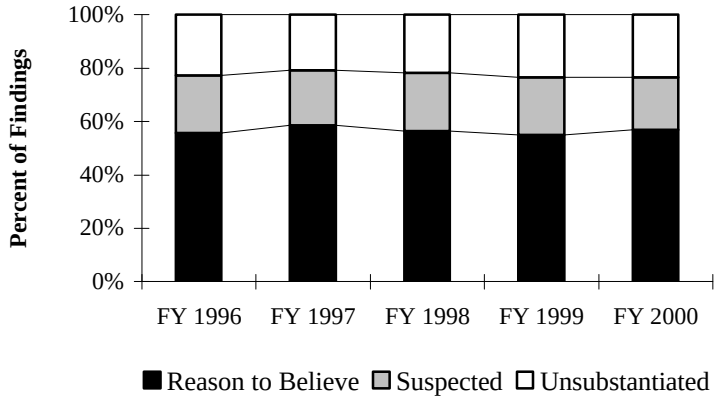
Completed investigations increased one percent in fiscal year 2000. Reason to believe findings increased nearly five percent while suspected findings decreased almost nine percent and unsubstantiated findings increased nearly one percent.

Fifty-seven percent of the investigations completed in fiscal year 2000 were found reason to believe. Suspected and unsubstantiated findings accounted for 19 percent and 24 percent, respectively.

Completed Investigative Findings of Home and Community
A/N/E of Seniors and Adults with Disabilities

	Reason to Believe	Annual Change	Suspected	Annual Change	Unsub-stantiated	Annual Change	Total	Annual Change
FY 1996	5,919	-6.7%	2,298	-3.2%	2,402	4.6%	10,619	-3.6%
FY 1997	6,432	8.7%	2,255	-1.9%	2,271	-5.5%	10,958	3.2%
FY 1998	6,630	3.1%	2,581	14.5%	2,550	12.3%	11,761	7.3%
FY 1999	6,851	3.3%	2,687	4.1%	2,929	14.9%	12,467	6.0%
FY 2000	7,169	4.6%	2,447	-8.9%	2,956	0.9%	12,572	0.8%

Investigative Findings of Home and Community
A/N/E
of Seniors and Adults with Disabilities



Types of Abuse, Neglect and Exploitation

The types of A/N/E include various forms of physical abuse and neglect, medical neglect, verbal abuse, and financial neglect or exploitation. For analysis purposes, the various types of A/N/E allegations have been grouped into the following seven categories: physical abuse, physical neglect, emotional abuse, emotional neglect, financial exploitation, financial neglect and other. (See Appendix A, page 23, for definitions). There was an average of three different types of A/N/E allegations per completed investigation during fiscal year 2000.

Physical neglect had the greatest number of reported incidents (19,799); however, 43 percent of these reported incidents were unsubstantiated. Emotional neglect was the type of A/N/E with the greatest proportion (47 percent) of incidents determined as reason to believe. Upon investigation, financial exploitation was most frequently found to be unsubstantiated (62 percent). New legislation defining financial exploitation as a crime with applicable penalties should result in a larger number of substantiated cases in the future.

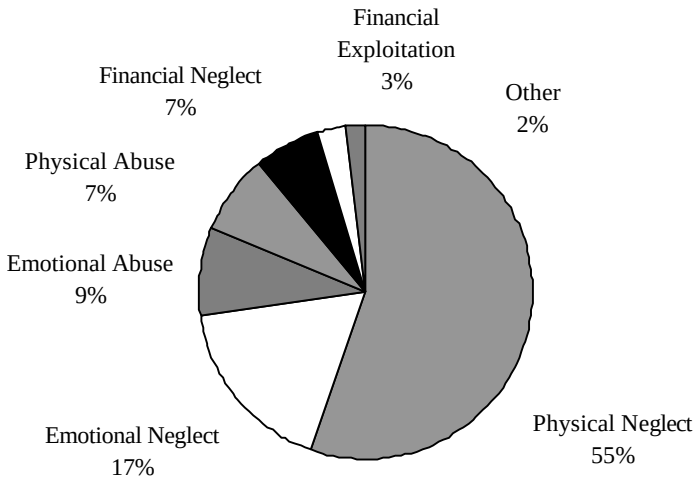
Types of A/N/E of Seniors and Adults with Disabilities

		Findings		
Type of A/N/E	Number of Incidents	Reason to Believe	Suspected	Unsub-stantiated
Physical Neglect	19,799	38%	19%	43%
Emotional Neglect	5,122	47%	23%	30%
Emotional Abuse	3,196	36%	25%	39%
Physical Abuse	2,709	38%	18%	44%
Financial Neglect	2,317	39%	19%	42%
Financial Exploitation	2,388	16%	22%	62%
Other	556	45%	13%	42%

Note: The number of incidents is not directly related to the number of reports as victims may be subjected to multiple types of A/N/E.

National studies have found neglect as the most common form of senior and disabled adult maltreatment in a home and community setting. Following the national trend, physical and emotional neglect were the most prevalent types of A/N/E found as reason to believe in Missouri. Abuse accounted for nearly 16 percent, and financial exploitation or neglect for ten percent of reason to believe A/N/E findings.

Types of Home and Community A/N/E of Seniors and Adults with Disabilities Found Reason to Believe FY 2000



Resolutions and Services Provided

Upon conclusion of the investigation, the majority of cases found reason to believe resulted in DA opening a case and providing protective services (27 percent) or the problem was resolved through a conclusive action or plan during the investigation (29 percent). Fourteen percent of the reported adults were placed in a long-term care facility or referred to another agency for help. (See table on page 10.)

Various services were provided to reported victims after investigation. In most cases, either the victim or his/her family received counseling from DA staff. Thirty-three percent were authorized for an in-home service, such as personal care, homemaker care or home delivered meals. Nineteen percent were provided legal or financial aid, including assignment of a guardian, a power of attorney or financial management. Fourteen percent of reported victims were placed in a long-term care facility, mental health facility or an alcohol and/or drug program. (See table on page 10.)

Resolutions of Home and Community A/N/E Investigations of Seniors and Adults with Disabilities FY 2000

Type of Service	Resolutions	Percentage
Conclusive Action or Plan	3,649	29.0%
Opened for Protective Services	3,414	27.2%
Substantiated, No Protective Services Needed	1,658	13.2%
Placed in Long-Term Care	1,221	9.7%
Refused Services	1,009	8.0%
Referred to Another Agency	498	4.0%
Client Died	476	3.8%
Client Moved	270	2.1%
Unable to Locate Client	151	1.2%
Other	226	1.8%
Total	**12,572**	**100.0%**

Services Provided to Reported Victims of Home and Community A/N/E FY 2000

Service	Number	Percentage*
Counseling	19,564	155.6%
In-Home Services	4,107	32.7%
Legal/Financial	2,431	19.3%
Placement	1,800	14.3%
Emergency Assistance	1,253	10.0%
Other Assistance	1,292	10.3%
No Services Needed	399	3.2%

***More than one service may be provided after an investigation. Percent is the percent of 12,572 investigations.**

Source and Nature of A/N/E

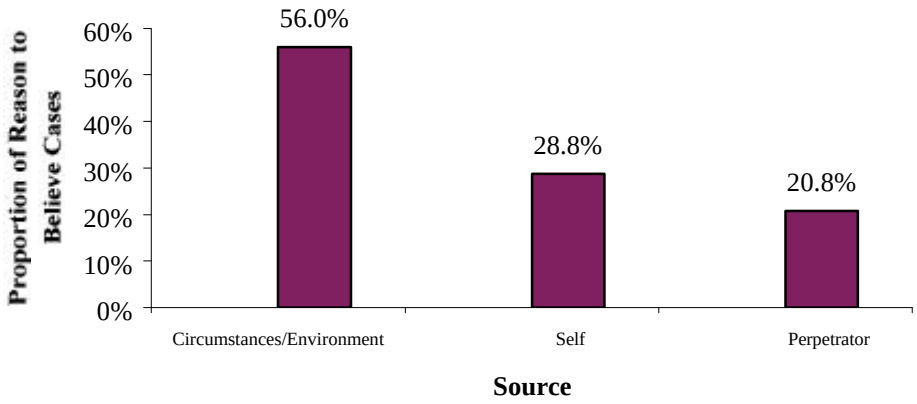
In Missouri as well as nationally, the majority of perpetrators of seniors and adults with disabilities are family members of the victims. Causes identified by researchers that contribute to the occurrence of abuse include caregiver stress; impairment of the dependent adult; a cycle of violence where abusive behavior is the normal response to tension or conflict because other ways to respond have not been learned; and personal problems of abusers such as mental and emotional disorders, alcoholism, drug addiction and financial difficulty. Please see Appendix B (page 26) for a listing of the natures of abuse.

The source and nature of A/N/E were examined for reason to believe cases. Circumstances or environment were found to be the source of A/N/E in more than half of the reason to believe cases. The nature of abuse found in these cases included the victim being incapable of self-care (25 percent), confusion of the victim (seven percent) and inadequate physical care (five percent). Conditions found in these living environments may include unclean or unsanitary shelter, spoiled food or physical fragility.

The reported adult was the source for nearly 29 percent of the cases found reason to believe. Self-abuse/neglect is characterized as the behavior of a person that threatens his/her own health or safety and generally manifests itself as a refusal or failure to provide himself/herself with adequate food, water, clothing, shelter, personal hygiene, medication and safety precautions.

Nearly 21 percent of the reason to believe cases were caused by a third party perpetrator. Fifteen percent of these reports were financial exploitation. Fourteen percent of these reports were the result of physical abuse such as beatings, bruises, cuts, burns or bone fractures and one percent were the result of sexual abuse.

Sources of ANE as a Proportion of Reason to Believe Cases FY 2000



Note: Percentages will add to more than 100% because A/N/E can be attributed to more than one source.

Victim Demographics

For fiscal year 2000, the typical victim of A/N/E was a 69 year old, white female who lived alone. The age and race of victims were similar for all sources of A/N/E. The sex of the victims differed by source. Victims of perpetrators were more likely than the other sources of A/N/E to be female. While the majority of the victims of self-abuse/neglect and circumstances/environment lived alone, victims of perpetrators were more likely to live with a relative.

Victim Demographics of Seniors and Adults with Disabilities
Reason to Believe Cases by Source of A/N/E
FY 2000

	Self	Circumstances/ Environment	Perpetrator	All Victims
Age				
18-59 Disabled	24.0%	23.3%	22.1%	22.8%
60-84 Elderly	58.4%	58.5%	58.7%	58.6%
85+ Frail Elderly	17.6%	18.2%	19.2%	18.6%
Average Age	69.1	69.5	69.4	69.6
Race				
White	77.1%	80.7%	78.0%	78.9%
African/American	20.4%	16.4%	19.4%	18.2%
Hispanic	0.3%	0.3%	0.3%	0.3%
Asian	0.2%	0.1%	0.2%	0.2%
Native American	0.1%	0.1%	0.2%	0.1%
Other	1.9%	2.4%	1.9%	2.3%
Sex				
Male	38.3%	36.1%	28.4%	35.8%
Female	61.7%	63.9%	71.6%	64.2%
Living Arrangements				
Living Alone	52.7%	48.5%	30.3%	48.0%
Living with Spouse	13.5%	16.7%	16.9%	15.6%
Living with Relative	23.8%	25.4%	38.2%	25.7%
Other	10.0%	9.4%	14.6%	10.7%

Perpetrator Demographics

An analysis of the demographic characteristics of perpetrators revealed that the typical perpetrator was white, younger than 50 years old, and related to the victim. Females were somewhat more likely than males to be perpetrators. This is partly attributable to the discrepancy between the sexes in our population and the prevalent sociological gender roles of females as the primary caregiver. Age was reported for 49 percent of perpetrators. In cases where age was reported, the majority of perpetrators were between the ages of 30 and 39 which differs from the age range for the majority of perpetrators in fiscal year 1999 (40-49 years).

Perpetrator Demographics of Reason to Believe Cases
FY 2000

Age*		**Relationship to Victim**	
Less than 30	20.7%	Adult Child	34.5%
30-39	23.1%	Other Relative	20.8%
40-49	19.6%	Spouse	12.9%
50-59	12.4%	In-Home Service Provider	13.7%
60-69	7.1%	Housemate/Friend/Neighbor	7.2%
70-79	8.2%	Health Care Professional	3.7%
80+	8.9%	Other	7.2%
Average Age	46.0		
Race		**Living With Victim**	
White	68.2%	Yes	48.1%
African American	20.1%	No	51.9%
Hispanic	0.2%		
Asian	0.2%		
Native American	0.1%		
Other	0.1%		
Not Reported	11.1%		
Sex			
Male	44.1%		
Female	53.7%		
Not Reported	2.2%		

* Age is based on the 49% of cases in which age was reported.

Initial Reports

The report process for abuse or neglect (A/N) or regulation violations in a long-term care facility is similar to the process for home and community A/N/E. The CRU workers log the necessary information and then forward the complaints to one of seven regional offices for investigation.

In fiscal year 2000, the CRU logged 7,541 institution related reports, an increase of nearly two percent from fiscal year 1999. The number of A/N reports increased to 787 following three years of decreasing reports. Regulation violations decreased nearly five percent from the previous year. Statements of concern were re-defined in 1998 and absorbed into other categories; therefore, they are no longer measured separately. A new category of self-reports was added in 1999. This category of reporting allows institutions to report incidents occurring in their facility. Following one full year of tracking self-reports, they represent nearly five percent of total reports.

In fiscal year 2000, A/N reports accounted for almost 11 percent of total institutional reports while allegations of regulatory violations were 84 percent.

Initial Reports of Institutional Abuse, Neglect and Regulation Violations FY 2000

Fiscal Year	Abuse/ Neglect	Regulation Violations	Statements of Concern	Self Reports	Total	Annual Change
FY 1996	886	5,956	801	N/A	7,643	8.3%
FY 1997	832	4,759	1,636	N/A	7,227	-5.4%
FY 1998	716	5,375	999	N/A	7,090	-1.9%
FY 1999	683	6,716	N/A	9	7,408	4.5%
FY 2000	787	6,382	N/A	372	7,541	1.8%

Reporters

Employees of long-term care (LTC) facilities and health care professionals that have a reasonable cause to suspect A/N of a facility resident are mandated by law to report the incident to the CRU. (See Appendix J, page 38, for a complete list of mandated reporters.)

Nearly 56 percent of A/N reports originated from long-term care facility employees, down from 57 percent last year. Directors of Nursing and administrators comprised 40 percent of the A/N reporters. Regulation violations were most often reported by anonymous or unknown sources (25 percent) the resident's child (16 percent) and directors of nursing (8.5 percent).

Reporters of Institutional Abuse/Neglect and Regulation Violations FY 2000

	Abuse/Neglect		Regulation Violations		Total	
	Number	Percent	Number	Percent	Number	Percent
Long-Term Care Employees	**437**	**55.5%**	**1,807**	**28.3%**	**2,244**	**31.3%**
Director of Nursing	153	19.4%	544	8.5%	697	9.7%
Administrator	160	20.3%	531	8.3%	691	9.6%
Other Employee	35	4.4%	185	2.9%	220	3.1%
LPN/RN	33	4.2%	156	2.4%	189	2.6%
Former Employee	23	2.9%	189	3.0%	212	3.0%
Nurse Aide	25	3.2%	148	2.3%	173	2.4%
Operator/Manager	8	1.0%	53	0.8%	61	0.9%
Instructor	0	0.0%	1	0.0%	1	0.0%
Relative	**94**	**11.9%**	**1,749**	**27.4%**	**1,843**	**25.7%**
Son/Daughter	55	7.0%	1,014	15.9%	1,069	14.9%
Other Relative	16	2.0%	254	4.0%	270	3.8%
Grandchild	7	0.9%	143	2.2%	150	2.1%
Sibling	9	1.1%	116	1.8%	125	1.7%
Spouse	3	0.4%	147	2.3%	150	2.1%
Parent	4	0.5%	75	1.2%	79	1.1%
Other	**256**	**32.5%**	**2,826**	**44.3%**	**3,082**	**43.0%**
Anonymous/Unknown	110	14.0%	1,580	24.8%	1,690	23.6%
Self	14	1.8%	388	6.1%	402	5.6%
Other*	31	3.9%	272	4.3%	303	4.2%
Friend/Neighbor	4	0.5%	164	2.6%	168	2.3%
Hospital Social Service Employee	43	5.5%	195	3.1%	238	3.3%
Health Care Professional	44	5.6%	131	2.1%	175	2.4%
DSS/Division of Aging Employee	10	1.3%	96	1.5%	106	1.5%
Total	**787**	**100.0%**	**6,382**	**100.0%**	**7,169**	**100.0%**

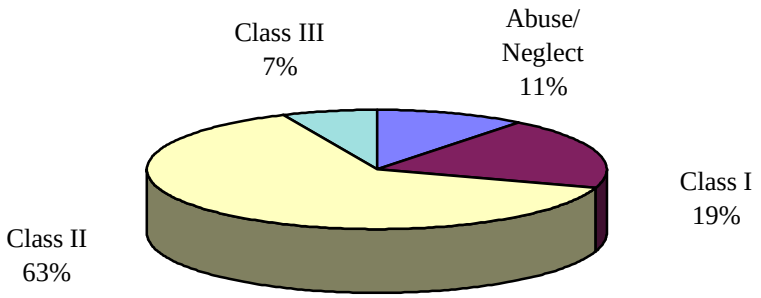
***** Other includes government officials, law enforcement, other residents, guardians, Area Agency on Aging, clergy, ombudsman and others.

Complaint Classification and Investigation Time Frames

In fiscal year 2000, the results of 8,704 completed institutional investigations were entered into the CRANE database. Complaints were classified based on the severity of the A/N and/or regulation violation, which then determined the time frame in which the investigator was to conduct the investigation.

A/N and Class I reports accounted for 30 percent of the investigated reports. Because of the possibility of imminent danger to residents, 91 percent of these reports were investigated within 24 hours. Class II and III reports, which are not indicative of imminent danger to residents, accounted for the remaining 69 percent of reports. For Class II reports, 64 percent were investigated within 30 days. Class III reports required an investigation at the next scheduled inspection or survey of the facility.

Classification of Institutional Abuse/Neglect and Regulation Violations FY 2000



Investigative Findings of Abuse/Neglect Allegations

During investigations, division staff determine the factuality of the reports and classify their findings into the following categories: valid, invalid and unable to verify. A report is determined to be valid when investigators conclude the allegation did occur and/or there was a statutory violation. Invalid is returned when a conclusion is reached that the allegation did not occur, or that it occurred but it is not a statutory violation. Unable to verify is the result when there is conflicting information to the extent that no conclusion can be reached.

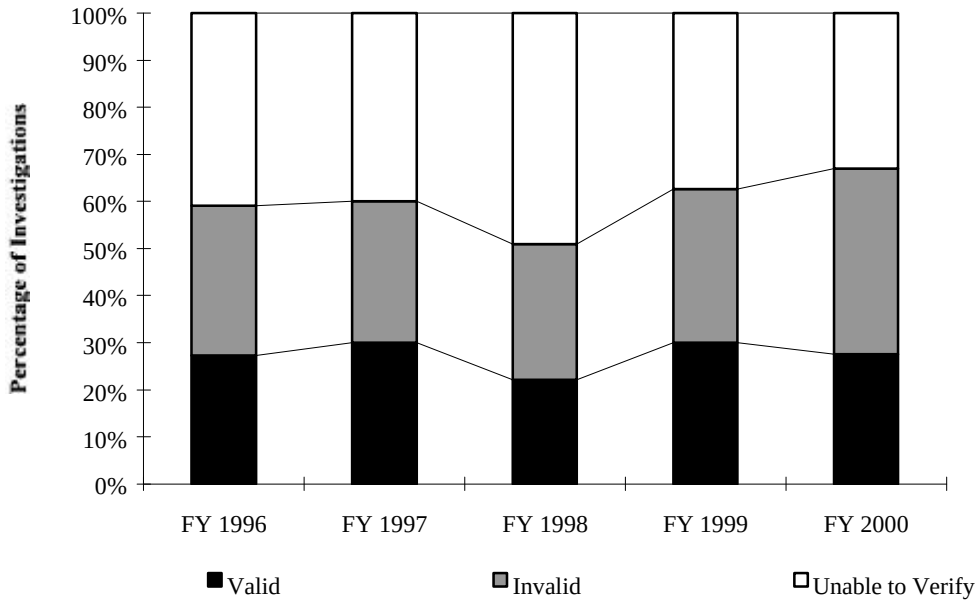
A total of 922 A/N complaint investigations were completed in fiscal year 2000. Given the almost 50 percent increase in completed investigations, the number of valid findings increased 37 percent while invalid findings increased 81 percent. Unable to verify findings increased 32 percent from fiscal year 1999 when this findings category was at its lowest.

Nearly 40 percent were determined to be invalid. The percentage of valid findings returned was 28 percent in fiscal year 2000, an increase of 37 percent from fiscal year 1999.

Completed Investigative Findings of Institutional Abuse/Neglect Reports

Fiscal Year	Valid	Percent of Total	Invalid	Percent of Total	Unable to Verify	Percent of Total	Total	Annual Change
FY 1996	237	27.3%	276	31.8%	355	40.9%	868	
FY 1997	256	30.1%	255	30.0%	340	39.2%	851	-2.0%
FY 1998	154	22.1%	202	28.9%	342	39.4%	698	-18.0%
FY 1999	185	30.0%	201	32.6%	230	26.5%	616	-11.7%
FY 2000	254	27.5%	364	39.5%	304	35.0%	922	49.7%

Completed Investigative Findings for Institutional Abuse/Neglect Reports



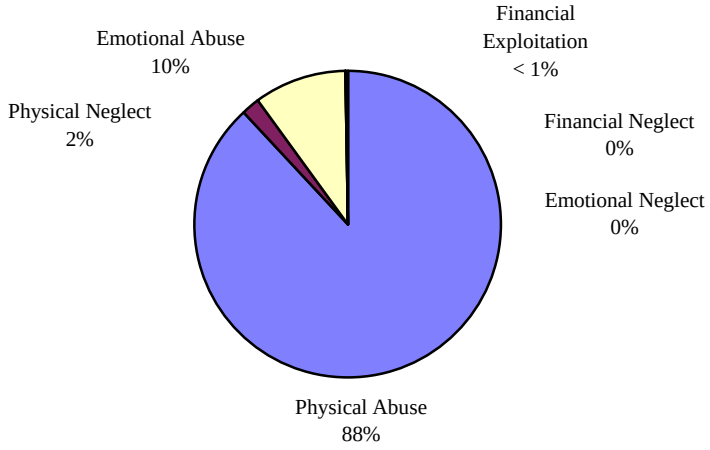
Types of Abuse/Neglect

Physical abuse was most often alleged in the institutional A/N reports but the allegations were most often found to be invalid or unverifiable. However, of valid findings, physical abuse was the highest reported type of A/N (88 percent). The majority of physical neglect allegations were found to be invalid while emotional abuse and financial exploitation were most often unable to be verified.

Types of Institutional Abuse/Neglect
FY 2000

Type of Abuse	Number of Allegations	Findings		
		Valid	Invalid	Unable to Verify
Physical Abuse	1278	25.8%	43.2%	31.0%
Physical Neglect	37	18.9%	70.3%	10.8%
Emotional Abuse	148	25.0%	48.0%	27.0%
Emotional Neglect	2	0.0%	100.0%	0.0%
Financial Exploitation	5	20.0%	60.0%	20.0%
Financial Neglect	1	0.0%	100.0%	0.0%

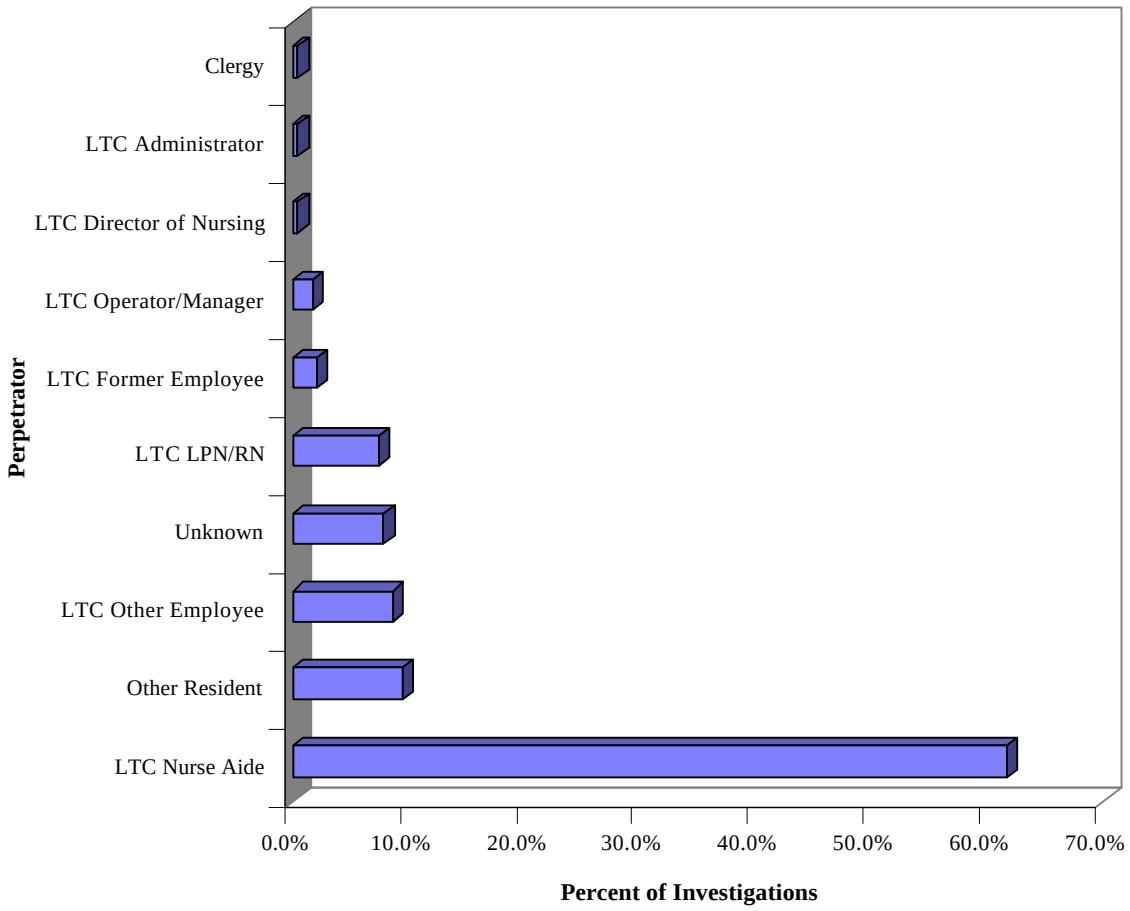
Types of Valid Institutional Abuse/Neglect
FY 2000



Perpetrators of Valid Abuse/Neglect Investigations

During fiscal year 2000, the most frequently identified perpetrators of abuse/neglect in long-term care facilities were nurse aides (62 percent) the same as in fiscal year 1999. Other residents were the perpetrators of valid abuse/neglect in 10 percent of investigations, similar to fiscal year 1999 (11 percent).

Identified Perpetrators of Valid Institutional Abuse/Neglect
FY 2000



Investigative Findings of Alleged Regulation Violations

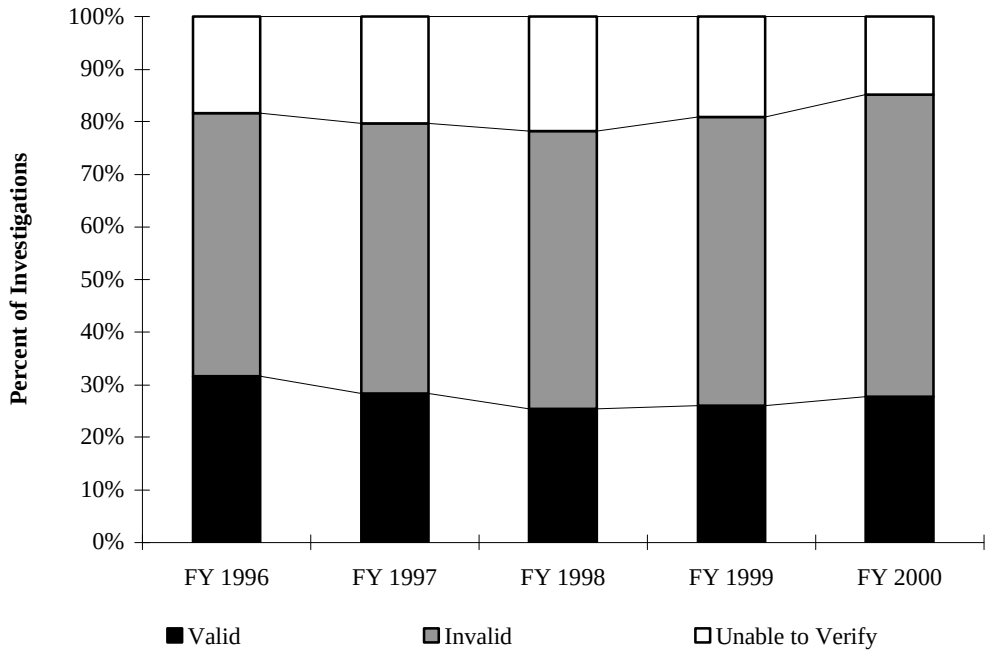
In fiscal year 2000, 7,782 complaint reports of regulation violations were investigated, a 34 percent increase from fiscal year 1999. All categories of findings increased this year with valid findings increasing the most (43 percent) followed by invalid findings (41 percent) and unable to verify findings (four percent).

The proportion of invalid findings increased to 57 percent. Valid findings accounted for 28 percent of all conclusions, slightly higher than in 1999. Unable to verify conclusions as a proportion of total findings have declined since 1998. Sixty-six of the 372 self-reports also generated a regulatory citation.

Completed Investigative Findings of Institutional Regulation Violations

Fiscal Year	Valid	Annual Change	Invalid	Annual Change	Unable to Verify	Annual Change	Total	Annual Change
1996	1,955	6.3%	3,096	3.2%	1,135	-4.8%	6,186	2.6%
1997	1,502	-23.2%	2,727	-11.9%	1,076	-5.2%	5,305	-14.2%
1998	1,205	-19.8%	2,501	-8.3%	1,032	-4.1%	4,738	-10.7%
1999	1,511	25.4%	3,174	26.9%	1,109	7.5%	5,794	22.3%
2000	2,164	43.2%	4,467	40.7%	1,151	3.8%	7,782	34.3%

Completed Investigative Findings of Institutional Regulation Violation Reports



Types of Regulation Violations

Regulation violations regarding resident care and resident rights were the most frequent allegations in reports. Investigators determined that nearly 24 percent of the resident care and 12 percent of the resident rights allegations to be valid. As a percentage, violations most often found to be valid included physical plant (27 percent) and resident care (24 percent) violations.

Types of Institutional Regulation Violations
FY 2000

Types of Regulation Violations	Number of Allegations	Findings		
		Valid	Invalid	Unable to Verify
Resident Care	5,894	24.0%	60.7%	15.3%
Nursing Care	849	20.3%	62.7%	17.1%
Resident Rights	1,559	12.3%	70.8%	16.9%
Personnel	991	20.3%	71.2%	8.5%
Dietary	731	12.9%	78.3%	8.9%
Sanitation	696	21.1%	71.7%	7.2%
Medications	605	19.5%	64.3%	16.2%
Physical Plant	381	27.3%	66.7%	6.0%
Personal Funds and Property	383	15.1%	64.0%	20.9%
Fire Safety	90	18.9%	76.7%	4.4%
Administrative Licensing	49	18.4%	69.4%	12.2%
Social and Emotional Needs	58	12.1%	69.0%	19.0%
Other	21	19.1%	76.2%	4.8%

Long-Term Care Ombudsman Program

The Missouri Ombudsman Program advocates to protect the health, safety, welfare and rights of residents in long-term care facilities. An Ombudsman is a citizen volunteer who acts on behalf of the resident to resolve problems, informs residents of their rights and provides information on resident needs to the community. While the Ombudsman program does not deal directly with abuse/neglect cases, it is felt that the presence of an ombudsman in a long-term care facility helps diffuse situations before they develop into abuse or neglect. Information concerning the Ombudsman program may be accessed by calling: **1 (800) 309-3282**.

During fiscal year 2000, ombudsmen handled 5,577 complaints made by or on behalf of nursing home residents. The majority of complaints concerned resident care and quality of life issues. The three most frequent complaints in nursing homes were care issues; resident rights of autonomy, choice, exercise of rights and privacy; and dietary.

Missouri Long-Term Care Ombudsman Program for FY 2000
Nursing Home and Residential Care Facility Complaints

	Nursing Home		Residential Care Facility	
Type of Complaint	Number of Complaints	Percent	Number of Complaints	Percent
Quality of Life	**1,396**	**25.0%**	**151**	**36.0%**
Dietary	550	9.9%	75	17.9%
Environmental Conditions	500	9.0%	41	9.8%
Activities and Social Services	346	6.2%	35	8.3%
Resident Care	**1,780**	**31.9%**	**78**	**18.6%**
Care Issues (personal assistance and hygiene)	1,425	25.6%	62	14.8%
Rehabilitation or Maintenance of Function	338	6.1%	15	3.6%
Restraints, Chemical and Physical	17	0.3%	1	0.2%
Resident Rights	**1,624**	**29.1%**	**141**	**33.6%**
Autonomy, Choice, Exercise of Rights, Privacy	710	12.7%	71	16.9%
Financial, Property (not financial exploitation)	460	8.2%	16	3.8%
Admission, Transfer, Discharge, Eviction	188	3.4%	30	7.1%
Access to Information	155	2.8%	13	3.1%
Abuse, Gross Neglect, Exploitation	111	2.0%	11	2.6%
Administration	**777**	**13.9%**	**50**	**11.9%**
Staffing	524	9.4%	21	5.0%
System/Other	183	3.3%	19	4.5%
Policies, Procedures, Attitudes, Resources	45	0.8%	8	1.9%
State Medicaid Agency	20	0.4%	1	0.2%
Certification/Licensing Agency	5	0.1%	1	0.2%
Total	**5,577**	**100.0%**	**420**	**100.0%**

General Terms*

A/N/E: Abuse, neglect or exploitation.

A/N: Abuse or neglect.

Abuse: The infliction of physical, sexual or emotional injury or harm.

Neglect: The failure by the individual or by those responsible for the care, custody and control of the individual, to provide services which are reasonable and necessary to maintain the physical and mental health of the individual, when such failure presents either an imminent danger to the health, safety, or welfare of the individual or a substantial probability that death or serious physical harm would result.

Eligible Adults: 1) Missouri residents who are aged 60 or older; 2) adults with physical or mental impairments that limit their ability to perform activities of daily living; and 3) residents of nursing facilities, residential care facilities, or ICF/MR facilities.

Financial Exploitation: A person in a position of trust and confidence obtains control of property by deceit or intimidation.

Investigator: Division of Aging worker that determines the validity of allegations contained in reports which allege abuse, neglect or exploitation of an eligible adult or a regulation violation in a facility licensed by the Division of Aging.

MCO Missouri Care Options: Program in which persons are informed about care options when facing decisions regarding long-term care.

Regulation Violation: Evidence of facility noncompliance with rules and regulations.

Statement of Concern: A complaint received about a facility, which is not within the regulatory jurisdiction of the Division of Aging or does not have any effect on resident care.

Perpetrator: An individual, other than the victim himself/herself or circumstances/environment, who committed the A/N/E.

*Terms as defined by applicable state statutes.

Classes of Home and Community Reports

Class I: Imminent danger or an emergency situation.

Class II: A/N/E that jeopardizes the health, safety or welfare of the reported adult, but does not create imminent danger.

Description of Home and Community Investigative Findings

Reason to Believe: Probable cause to believe that allegations are legitimate based on investigative findings.

Suspected: Information gathered is insufficient to establish facts, but suggests the eligible adult suffered injury or harm.

Unsubstantiated: Information obtained indicates that allegations are inaccurate, misinterpreted, or did not present a risk of danger or harm to the eligible adult.

Classes of Institutional Reports

A/N: The infliction of physical, sexual or emotional injury or harm; or the failure to provide, by those responsible for the care and custody of a resident in a facility, the services which are reasonable and necessary to maintain the physical and mental health of the resident when such failure presents imminent danger or a substantial probability that death or serious physical harm would result.

Class I: A violation of regulations which would present either an imminent danger to the health, safety or welfare of any resident or a substantial probability that death or serious physical harm would result.

Class II: Violations which have a direct or immediate relation to the health, safety or welfare of any resident, but which do not create an imminent danger.

Class III: Violations which have an indirect or potential impact on the health, safety or welfare of any resident.

Description of Institutional Investigative Findings

Valid: A conclusion the allegation did occur and there was a statutory violation; or, a conclusion that there is a reasonable likelihood that the allegation did occur and there was a statutory or regulation violation.

Unable to Verify: There is conflicting information collected to the extent that no conclusion could be reached.

Invalid: A conclusion that the allegation did not occur; a conclusion that there is not a reasonable likelihood that the allegation occurred; or, a conclusion that the allegation either occurred, or there is a reasonable likelihood that it occurred, but there is not a statutory or regulatory violation.

Types of Abuse, Neglect and Exploitation

Emotional Abuse: Emotional/verbal abuse, harassment, and family discord.

Emotional Neglect: Emotionally disturbed, behavior problems, confused, depressed, suicidal, stressed.

Financial Exploitation: A person in a position of trust and confidence obtains control of property by deceit or intimidation.

Financial Neglect: Financial management needed, financially needy, legal need, guardian needed.

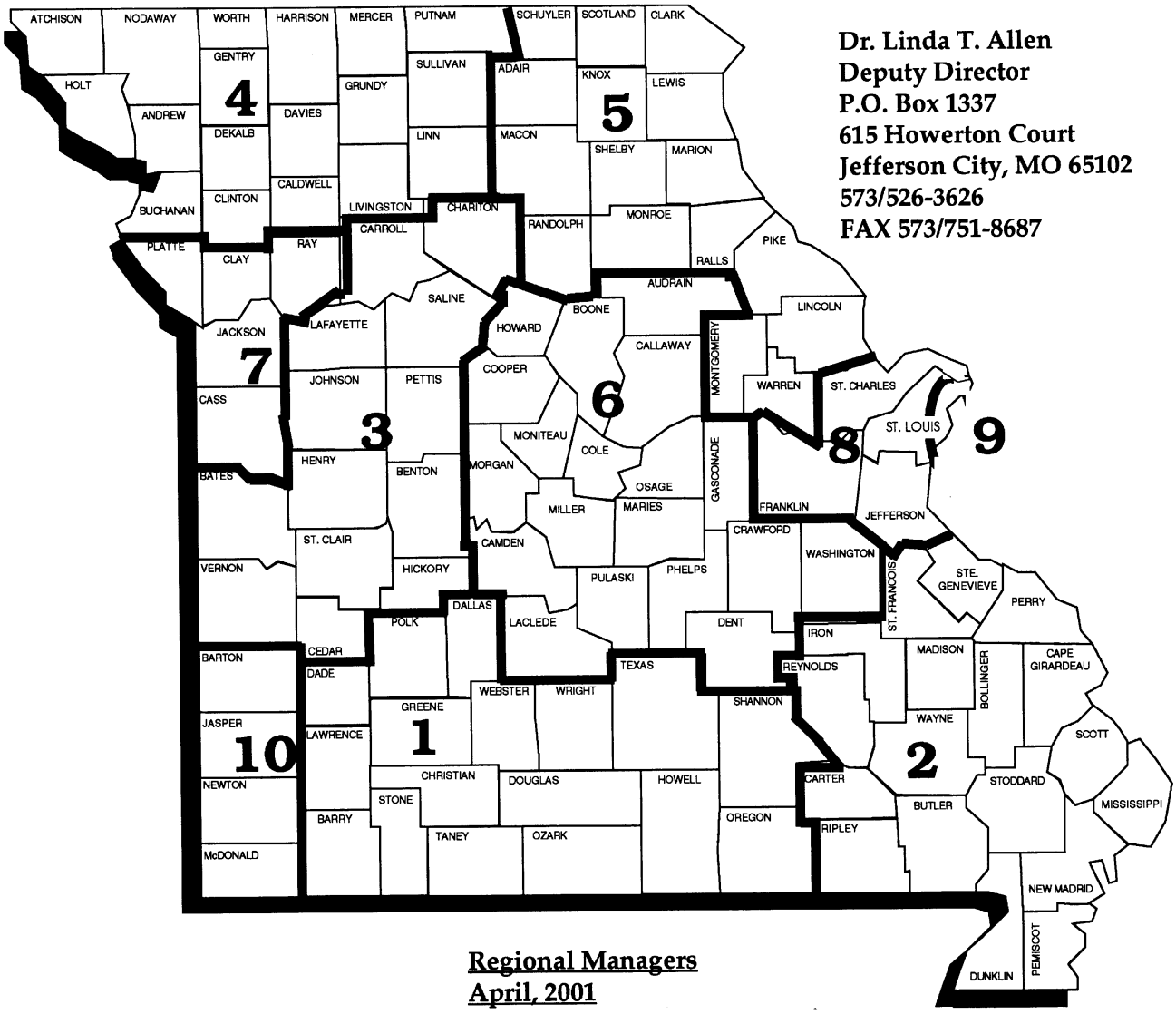
Physical Abuse: Beatings, bruises/welts, cuts/burns, bone fractures, sexual abuse, locked in/out of home, evicted, substance abuse.

Physical Neglect: Self-care limitation, inadequate physical care, disregard for personal safety, isolation, inadequate utilities, poor nutrition, medical neglect, inadequate supervision, filth/vermin/squalor, placement needed, heavy care responsibility.

Nature of Abuse

Beatings
Bruises/Welts
Cuts/Wounds
Bone Fractures
Sexual Abuse
Physical Restraint
Locked In/Out Home
Eviction
Medical Abuse
Substance Abuse
Incapable of Self Care
Inadequate Physical Care
Disregard Personal Safety
Isolation
Inadequate Housing
Inadequate Utilities
Inadequate Food
Medical Neglect
Improper Supervision
Filth/Squalor
Placement Needed
Heavy Care Responsibility
Emotional Abuse
Verbal Abuse
Harrassment
Family Discord
Emotionally Disturbed
Behavior Problems
Confused
Depressed
Suicidal
Stressed
Financial Exploitation
Financial Management Needed
Financial Need
Legal Need
Guardian Needed
Other

Missouri Division of Aging-Home & Community Services



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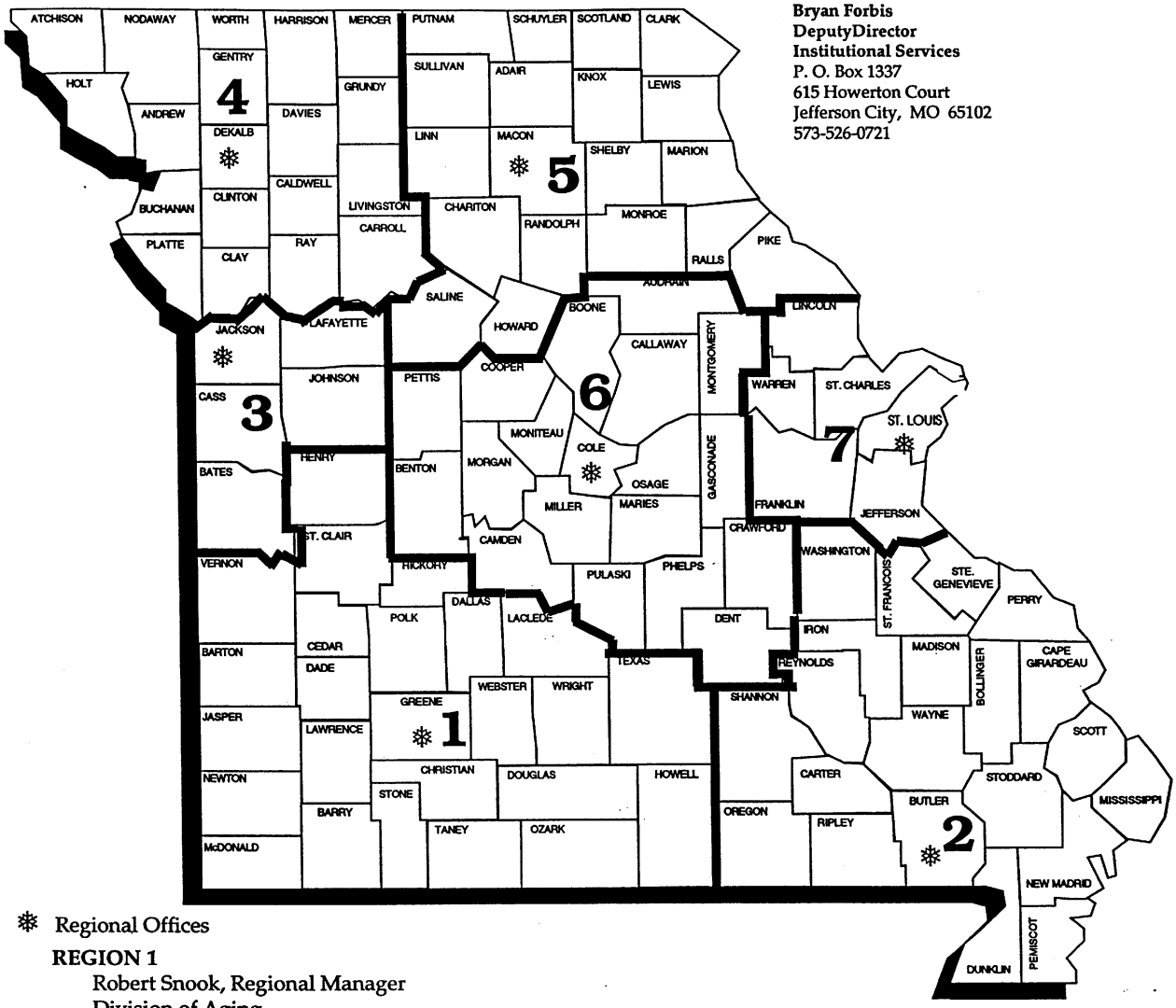

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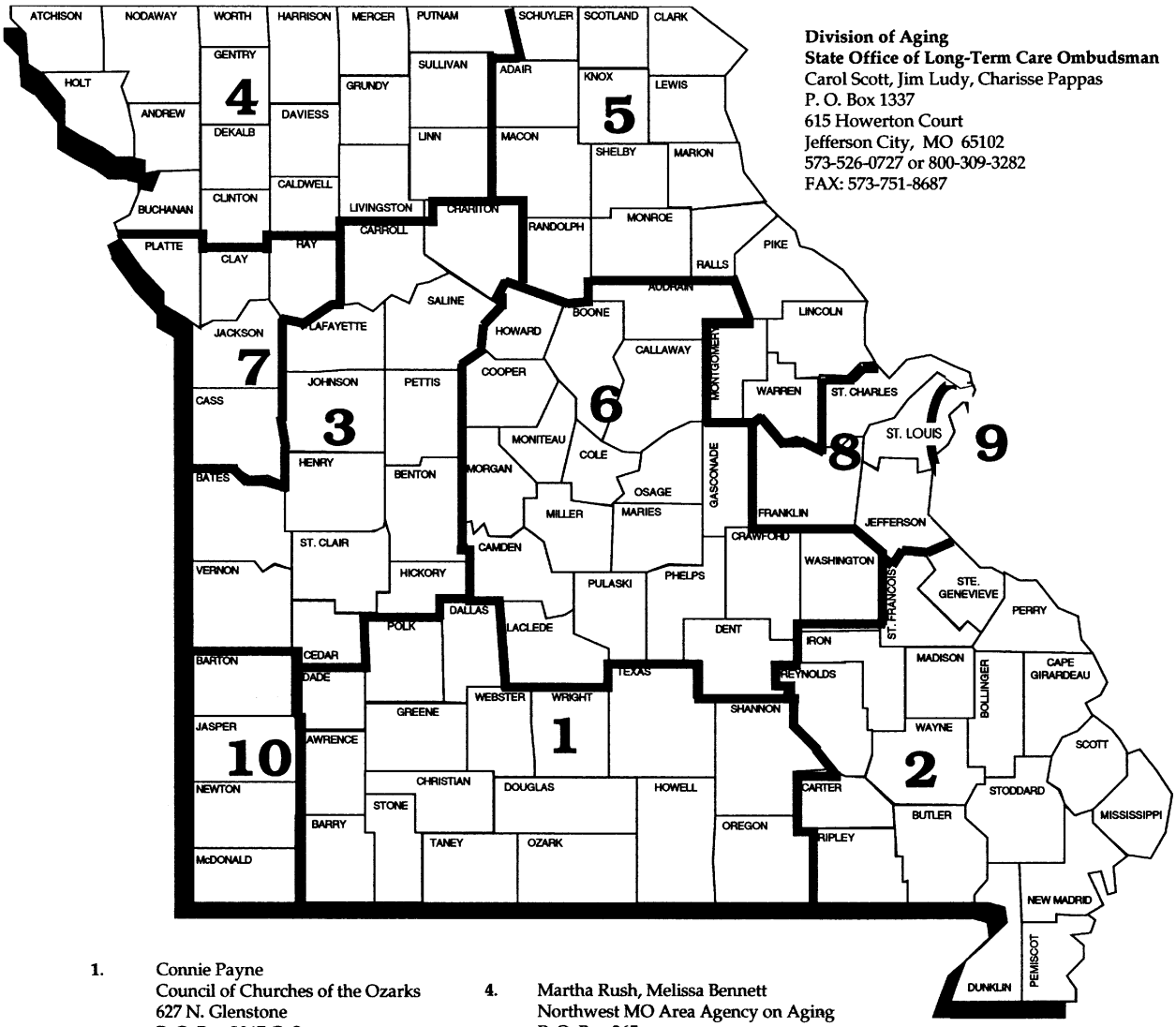
Missouri LTC Ombudsman Program



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Appendix F.
Initial Reports of Home & Community Abuse, Neglect and Exploitation
of Seniors and Adults with Disabilities by County and Service Region for FY 2000

		Disabled Adults Ages 18-59	Older Adults Ages 60+	Total
Region 1	Barry	3	63	66
	Christian	23	70	93
	Dade	4	25	29
	Dallas	8	23	31
	Douglas	8	32	40
	Greene	143	482	625
	Howell	14	90	104
	Lawrence	13	42	55
	Oregon	15	27	42
	Ozark	4	26	30
	Polk	13	33	46
	Shannon	4	7	11
	Stone	5	52	57
	Taney	17	87	104
	Texas	18	65	83
	Webster	9	41	50
	Wright	12	43	55
	Regional Total	**313**	**1,208**	**1,521**
Region 2	Bollinger	16	37	53
	Butler	81	254	335
	Cape Girardeau	47	109	156
	Carter	11	26	37
	Dunklin	37	122	159
	Iron	30	27	57
	Madison	11	49	60
	Mississippi	24	55	79
	New Madrid	39	116	155
	Pemiscot	29	112	141
	Perry	9	17	26
	Reynolds	7	17	24
	Ripley	7	44	51
	St. Francois	79	204	283
	Ste Genevieve	6	19	25
	Scott	50	149	199
	Stoddard	18	58	76
	Wayne	21	39	60
	Regional Total	**522**	**1,454**	**1,976**
Region 3	Bates	8	16	24
	Benton	10	33	43
	Carroll	4	11	15
	Cedar	3	19	22
	Chariton	4	12	16
	Henry	15	39	54
	Hickory	2	10	12
	Johnson	17	27	44
	Lafayette	11	42	53
	Pettis	26	89	115
	St Clair	3	10	13
	Saline	13	52	65
	Vernon	10	15	25
	Regional Total	**126**	**375**	**501**
Region 4	Andrew	3	26	29
	Atchison	0	6	6
	Buchanan	53	257	310
	Caldwell	5	25	30
	Clinton	12	33	45
	Daviess	2	21	23
	DeKalb	7	20	27
	Gentry	8	13	21
	Grundy	6	19	25
	Harrison	2	34	36
	Holt	1	7	8
	Linn	13	38	51

		Disabled Adults Ages 18-59	Older Adults Ages 60+	Total
	Livingston	0	26	26
	Mercer	3	16	19
	Nodaway	6	27	33
	Putnam	3	3	6
	Sullivan	7	26	33
	Worth	3	10	13
	Regional Total	**134**	**607**	**741**
Region 5	Adair	25	73	98
	Clark	5	26	31
	Knox	6	40	46
	Lewis	7	20	27
	Lincoln	15	59	74
	Macon	6	51	57
	Marion	15	56	71
	Monroe	2	25	27
	Montgomery	3	10	13
	Pike	14	50	64
	Ralls	4	7	11
	Randolph	21	92	113
	Schulyler	4	12	16
	Scotland	7	34	41
	Shelby	5	17	22
	Warren	5	19	24
	Regional Total	**144**	**591**	**735**
Region 6	Audrain	12	46	58
	Boone	68	141	209
	Callaway	16	56	72
	Camden	12	58	70
	Cole	44	92	136
	Cooper	15	25	40
	Crawford	16	53	69
	Dent	17	39	56
	Gasconade	8	45	53
	Howard	5	23	28
	Laclede	26	58	84
	Maries	5	22	27
	Miller	17	59	76
	Moniteau	6	29	35
	Morgan	22	44	66
	Osage	7	17	24
	Phelps	23	109	132
	Pulaski	31	93	124
	Washington	27	40	67
	Regional Total	**377**	**1,049**	**1,426**
Region 7	Cass	28	74	102
	Clay	70	200	270
	Jackson	486	1,647	2,133
	Platte	24	56	80
	Ray	7	34	41
	Regional Total	**615**	**2,011**	**2,626**
Region 8	Franklin	44	194	238
	Jefferson	82	248	330
	St Charles	42	178	220
	St Louis County	358	1,639	1,997
	Regional Total	**526**	**2,259**	**2,785**
Region 9	St Louis City	396	1,557	1,953
Region 10	Barton	6	17	23
	Jasper	65	259	324
	McDonald	13	24	37
	Newton	19	65	84
	Regional Total	**103**	**365**	**468**
	State Total	**3,256**	**11,476**	**14,732**

		Reason to Believe	Suspected	Unsubstantiated	Total
Region 1	Barry	30	14	14	58
	Christian	38	21	24	83
	Dade	26	2	5	33
	Dallas	19	2	3	24
	Douglas	20	10	10	40
	Greene	318	100	150	568
	Howell	47	7	20	74
	Lawrence	21	11	23	55
	Oregon	31	1	8	40
	Ozark	22	2	6	30
	Polk	23	5	7	35
	Shannon	2	2	2	6
	Stone	33	9	6	48
	Taney	74	16	20	110
	Texas	44	9	9	62
	Webster	31	3	9	43
	Wright	30	6	15	51
	Regional Total	**809**	**220**	**331**	**1,360**
Region 2	Bollinger	43	1	11	55
	Butler	165	19	90	274
	Cape Girardeau	93	19	24	136
	Carter	21	0	14	35
	Dunklin	85	13	30	128
	Iron	22	4	18	44
	Madison	45	3	8	56
	Mississippi	65	7	6	78
	New Madrid	106	16	19	141
	Pemiscot	71	19	24	114
	Perry	12	4	3	19
	Reynolds	10	7	6	23
	Ripley	39	2	14	55
	St Francois	178	55	30	263
	Ste Genevieve	7	4	12	23
	Scott	92	32	51	175
	Stoddard	28	11	19	58
	Wayne	37	2	15	54
	Regional Total	**1,119**	**218**	**394**	**1,731**
Region 3	Bates	14	6	2	22
	Benton	27	8	4	39
	Carroll	8	1	4	13
	Cedar	10	6	2	18
	Chariton	8	1	4	13
	Henry	23	12	10	45
	Hickory	6	2	2	10
	Johnson	23	8	9	40
	Lafayette	18	14	11	43
	Pettis	70	11	19	100
	St Clair	3	2	3	8
	Saline	41	15	6	62
	Vernon	11	6	6	23
	Regional Total	**262**	**92**	**82**	**436**
Region 4	Andrew	11	11	9	31
	Atchison	2	4	6	12
	Buchanan	176	70	59	305
	Caldwell	25	2	5	32
	Clinton	32	6	4	42
	Daviess	21	0	3	24
	DeKalb	13	5	7	25
	Gentry	12	3	2	17
	Grundy	9	4	7	20
	Harrison	19	9	5	33
	Holt	2	6	1	9
	Linn	27	6	14	47

		Reason to Believe	Suspected	Unsubstantiated	Total
	Livingston	17	0	10	27
	Mercer	14	3	0	17
	Nodaway	18	9	8	35
	Putnam	8	0	1	9
	Sullivan	21	2	5	28
	Worth	10	2	1	13
	Regional Total	**437**	**142**	**147**	**726**
Region 5	Adair	66	8	16	90
	Clark	24	4	3	31
	Knox	39	3	7	49
	Lewis	14	6	6	26
	Lincoln	47	5	8	60
	Macon	39	4	5	48
	Marion	39	4	19	62
	Monroe	11	5	4	20
	Montgomery	9	1	6	16
	Pike	43	10	9	62
	Ralls	4	2	2	8
	Randolph	73	12	17	102
	Schuyler	6	7	5	18
	Scotland	31	5	2	38
	Shelby	11	5	2	18
	Warren	13	2	5	20
	Regional Total	**469**	**83**	**116**	**668**
Region 6	Audrain	27	12	6	45
	Boone	96	35	49	180
	Callaway	41	2	13	56
	Camden	41	7	11	59
	Cole	68	8	24	100
	Cooper	20	6	8	34
	Crawford	48	5	14	67
	Dent	29	8	6	43
	Gasconade	35	1	12	48
	Howard	22	1	2	25
	Laclede	32	8	15	55
	Maries	17	4	1	22
	Miller	12	41	10	63
	Moniteau	20	3	10	33
	Morgan	49	2	11	62
	Osage	16	5	2	23
	Phelps	63	34	32	129
	Pulaski	83	5	35	123
	Washington	30	14	26	70
	Regional Total	**749**	**201**	**287**	**1,237**
Region 7	Cass	59	12	7	78
	Clay	106	68	46	220
	Jackson	989	433	441	1,863
	Platte	47	4	12	63
	Ray	30	2	2	34
	Regional Total	**1,231**	**519**	**508**	**2,258**
Region 8	Franklin	113	40	42	195
	Jefferson	183	59	36	278
	St Charles	112	28	41	181
	St Louis County	762	375	409	1,546
	Regional Total	**1,170**	**502**	**528**	**2,200**
Region 9	St Louis City	799	333	420	1,552
	Regional Total	**799**	**333**	**420**	**1,552**
Region 10	Barton	10	8	2	20
	Jasper	41	108	120	269
	McDonald	28	2	5	35
	Newton	45	19	16	80
	Regional Total	**124**	**137**	**143**	**404**
	State Total	**7,169**	**2,447**	**2,956**	**12,572**

Appendix H.
Initial Reports of Institutional Abuse, Neglect and Regulation Violations
By County and Service Region for FY 2000

		Abuse, Neglect	Regulation Violations	Total
Region 1	Barry	2	13	15
	Barton	0	8	8
	Cedar	1	11	12
	Christian	12	27	39
	Dade	1	6	7
	Dallas	0	9	9
	Douglas	0	16	16
	Greene	28	290	318
	Henry	5	17	22
	Hickory	0	2	2
	Howell	4	42	46
	Jasper	20	130	150
	Laclede	3	42	45
	Lawrence	4	31	35
	McDonald	1	17	18
	Newton	3	116	119
	Ozark	0	3	3
	Polk	7	25	32
	St Clair	3	3	6
	Stone	1	16	17
	Taney	2	27	29
	Texas	1	7	8
	Vernon	5	35	40
	Webster	2	26	28
	Wright	0	15	15
	Regional Total	**105**	**934**	**1,039**
Region 2	Bollinger	0	24	24
	Butler	3	51	54
	Cape Girardeau	7	70	77
	Carter	1	1	2
	Dunklin	4	40	44
	Iron	0	16	16
	Madison	0	15	15
	Mississippi	0	7	7
	New Madrid	3	22	25
	Oregon	0	9	9
	Pemiscott	0	9	9
	Perry	2	32	34
	Reynolds	0	6	6
	Ripley	0	12	12
	St Francois	7	88	95
	Ste Genevieve	2	16	18
	Scott	3	37	40
	Shannon	0	4	4
	Stoddard	4	28	32
	Wayne	0	10	10
	Regional Total	**36**	**497**	**533**
Region 3	Bates	1	9	10
	Cass	11	52	63
	Clay	15	142	157
	Jackson	105	693	798
	Johnson	4	23	27
	Lafayette	2	25	27
	Regional Total	**138**	**944**	**1,082**
Region 4	Andrew	2	23	25
	Atchison	0	6	6
	Buchanan	9	71	80
	Caldwell	3	21	24
	Carroll	1	11	12
	Clinton	2	21	23
	Daviess	2	17	19
	DeKalb	3	35	38

		Abuse, Neglect	Regulation Violations	Total
	Gentry	0	16	16
	Grundy	1	9	10
	Harrison	0	5	5
	Holt	0	6	6
	Livingston	1	10	11
	Mercer	0	4	4
	Nodaway	2	15	17
	Platte	4	75	79
	Ray	1	16	17
	Worth	1	2	3
	Regional Total	**32**	**363**	**395**
Region 5	Adair	3	23	26
	Chariton	2	26	28
	Clark	0	2	2
	Howard	0	15	15
	Knox	5	20	25
	Lewis	2	5	7
	Linn	1	13	14
	Macon	1	13	14
	Marion	11	63	74
	Monroe	4	10	14
	Pike	2	11	13
	Putnam	1	2	3
	Ralls	1	11	12
	Randolph	3	46	49
	Saline	4	29	33
	Schuyler	0	1	1
	Scotland	1	10	11
	Shelby	0	5	5
	Sullivan	0	9	9
	Regional Total	**41**	**314**	**355**
Region 6	Audrain	2	19	21
	Benton	2	17	19
	Boone	7	131	138
	Callaway	6	47	53
	Camden	1	22	23
	Cole	10	117	127
	Cooper	6	22	28
	Crawford	2	62	64
	Dent	1	14	15
	Gasconade	0	6	6
	Maries	0	4	4
	Miller	4	27	31
	Moniteau	1	19	20
	Montgomery	0	26	26
	Morgan	1	24	25
	Osage	6	18	24
	Pettis	2	49	51
	Phelps	4	38	42
	Pulaski	2	34	36
	Regional Total	**57**	**696**	**753**
Region 7	Franklin	2	53	55
	Jefferson	16	242	258
	Lincoln	4	45	49
	St Charles	7	90	97
	St Louis County	136	1,176	1,312
	Warren	2	13	15
	Washington	0	22	22
	St Louis City	41	409	450
	Regional Total	**208**	**2,050**	**2,258**
	State Total	**617**	**5,798**	**6,415**

Appendix I.
Investigative Findings of Institutional Abuse, Neglect and Regulation Violations
By County and Service Region for FY 2000

		Valid	Invalid, Not in Violation	Unable to Verify	Total
Region 1	Barry	3	8	4	15
	Barton	1	6	1	8
	Cedar	2	7	3	12
	Christian	11	17	11	39
	Dade	4	2	1	7
	Dallas	3	5	1	9
	Douglas	6	8	2	16
	Greene	74	163	81	318
	Henry	8	9	5	22
	Hickory	0	2	0	2
	Howell	19	20	7	46
	Jasper	40	70	40	150
	Laclede	13	24	8	45
	Lawrence	11	11	13	35
	McDonald	8	8	2	18
	Newton	45	50	24	119
	Ozark	0	2	1	3
	Polk	14	16	2	32
	St Clair	3	2	1	6
	Stone	7	8	2	17
	Taney	7	14	8	29
	Texas	2	4	2	8
	Vernon	11	16	12	39
	Webster	7	15	6	28
	Wright	3	11	1	15
	Regional Total	**302**	**498**	**238**	**1,038**
Region 2	Bollinger	13	11	0	24
	Butler	11	41	2	54
	Cape Girardeau	14	60	3	77
	Carter	0	2	0	2
	Dunklin	7	32	5	44
	Iron	4	12	0	16
	Madison	3	12	0	15
	Mississippi	1	6	0	7
	New Madrid	3	20	2	25
	Oregon	0	9	0	9
	Pemiscott	1	8	0	9
	Perry	8	24	2	34
	Reynolds	0	6	0	6
	Ripley	1	10	1	12
	St Francois	14	75	6	95
	Ste Genevieve	6	11	1	18
	Scott	5	35	0	40
	Shannon	2	2	0	4
	Stoddard	7	25	0	32
	Wayne	1	9	0	10
	Regional Total	**101**	**410**	**22**	**533**
Region 3	Bates	1	7	2	10
	Cass	13	34	16	63
	Clay	25	102	30	157
	Jackson	98	562	137	797
	Johnson	3	19	5	27
	Lafayette	2	20	5	27
	Regional Total	**142**	**744**	**195**	**1,081**
Region 4	Andrew	7	16	2	25
	Atchison	2	4	0	6
	Buchanan	28	41	11	80
	Caldwell	13	10	1	24
	Carroll	4	7	1	12
	Clinton	9	12	2	23
	Daviess	2	12	5	19
	DeKalb	14	19	5	38

		Valid	Invalid, Not in Violation	Unable to Verify	Total
	Gentry	7	8	1	16
	Grundy	5	4	1	10
	Harrison	0	5	0	5
	Holt	1	5	0	6
	Livingston	3	7	1	11
	Mercer	1	3	0	4
	Nodaway	1	12	4	17
	Platte	35	33	11	79
	Ray	8	6	3	17
	Worth	2	1	0	3
	Regional Total	**142**	**205**	**48**	**395**
Region 5	Adair	12	10	4	26
	Chariton	14	11	3	28
	Clark	1	1	0	2
	Howard	4	10	1	15
	Knox	16	6	3	25
	Lewis	4	2	1	7
	Linn	1	9	4	14
	Macon	4	9	1	14
	Marion	36	30	8	74
	Monroe	4	5	5	14
	Pike	3	9	1	13
	Putnam	2	1	0	3
	Ralls	3	8	1	12
	Randolph	17	28	4	49
	Saline	7	21	5	33
	Schuyler	1	0	0	1
	Scotland	6	3	2	11
	Shelby	2	2	0	4
	Sullivan	3	6	0	9
	Regional Total	**140**	**171**	**43**	**354**
Region 6	Audrain	2	16	3	21
	Benton	4	13	2	19
	Boone	45	58	35	138
	Callaway	11	35	7	53
	Camden	5	15	3	23
	Cole	39	59	29	127
	Cooper	9	13	6	28
	Crawford	25	31	8	64
	Dent	2	10	3	15
	Gasconade	0	6	0	6
	Maries	3	1	0	4
	Miller	6	23	2	31
	Moniteau	3	14	3	20
	Montgomery	10	14	2	26
	Morgan	4	19	2	25
	Osage	8	13	3	24
	Pettis	8	31	12	51
	Phelps	8	31	3	42
	Pulaski	6	25	5	36
	Regional Total	**198**	**427**	**128**	**753**
Region 7	Franklin	15	24	16	55
	Jefferson	74	121	63	258
	Lincoln	23	14	12	49
	St Charles	34	42	21	97
	St Louis County	359	515	434	1,308
	Warren	1	8	6	15
	Washington	14	6	2	22
	St Louis City	148	190	111	449
	Regional Total	**668**	**920**	**665**	**2,253**
	State Total	**1,693**	**3,375**	**1,339**	**6,407**

Professionals mandated to report in accordance with:	660.300	565.188	198.070
Adult Day Care Center Workers		yes	yes
Chiropractors	yes	yes	yes
Christian Science Practitioners	yes	yes	yes
Clinic personnel engaged in treatment, examination, care; adults 60+		yes	
Clinic personnel engaged in the examination of person age 60+			yes
Coroner		yes	yes
Dentist	yes	yes	yes
Department of Health Employee	yes		
Department of Mental Health Employee	yes		yes
Department of Social Services Employee	yes		yes
Facility Administrator			yes
Facility Employee (also see Nursing Home Worker)			yes
Health practitioners engaged in treatment, examination, care; persons age 60+		yes	
Hospital personnel engaged in treatment, examination, care; adults age 60+		yes	
In-Home Services employees, operators and owners	yes		
Interns (also see Resident Intern)			yes
Law Enforcement Officials (also see Peace Officers)		yes	yes
Medical Examiner	yes	yes	yes
Mental Health Professionals		yes	yes
Ministers	yes		yes
Nurse (also see Registered Nurse)	yes	yes	yes
Nursing Home Worker (also see facility employee)		yes	
Optometrist	yes	yes	yes
Other Health Practitioner			yes
Other person with responsibility for the care of persons 60+		yes	
Other person with responsibility for the care of an eligible adult			yes
Peace Officer	yes	yes	yes
Pharmacist	yes		yes
Physical Therapist	yes		yes
Physician	yes	yes	yes
Podiatrist	yes	yes	yes
Probation or Parole Officer		yes	yes
Psychologist	yes	yes	yes
Registered Nurse (also see Nurse)	yes	yes	
Resident Intern	yes	yes	
Social Worker	yes	yes	yes

* 660.300 Abuse/Neglect of in-home services clients 198.070 Resident of a nursing facility has been abused or neglected
565.188 Person (age 60 or older) has been subjected to conditions which would reasonably result in abuse or neglect